Form 11 **KENTUCKY DEPARTMENT OF WORKERS CLAIMS**
Effective 10/6/2000 **657 Chamberlin Avenue**
FRANKFORT KY 40601
Workers Compensation Claim no. _____

Motion to Substitute Party and Continue Benefits

Come now the undersigned, being all dependents of the deceased Plaintiff, _____ and hereby move to be substituted as the Plaintiff herein for the purpose of receipt of benefits, and further state as follows:

1. Employee/Plaintiff:_____
2. Date of death (attach copy of Death Certificate):_____
3. Cause of death: _____
4. Date of Award/Settlement and amount: _____
5. Date of Marriage (attach copy of Marriage Certificate): _____
6. List of dependent(s) (attach copies of Birth Certificates):

NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	RELATION-SHIP	ADDRESS (city, state, zip code)

Wherefore, the dependent(s) request that he/she (they) be substituted as the Plaintiff and that said benefits be paid directly to him/her (them).

Respectfully submitted,

_____
(Signature)

The undersigned hereby states that the foregoing is true and accurate to the best of my knowledge and belief.

_____
(Signature)

Subscribed and sworn to before me by _____ on this _____ day of _____, 20____.

_____
Notary Public, Kentucky, State at Large
My commission expires: _____

I certify that copies were mailed this _____ day of _____, 20_____ to:
Employer or Attorney for Employer: _____
Special Fund (if applicable): _____

Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement or claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.